IOD Review Meeting Notes
12/2/98 (Day 1)

Distribution authorized to U.S. Government Agencies and their contractors for the purpose of administering TRICARE (12/12/2000). Other requests for this document shall be referred to the Defense Manpower Data Center.

Referenced Documents:

DEERS/MHS Redesign Briefing
DEERS 3 New Medical
Interface Operation Description version 11
Current DEERS Medical Eligibility Matched Against New DEERS Health Care Delivery Program Options
DEERS/MEDICAL Terms

Discussion:

I. *DEERS/MHS Redesign Briefing Document*: Presented by Janine Groth
A. Drivers for the Redesign of DEERS/MHS:

- Entitlement rules and regulations have increased substantially. The Legacy System did not have enough flexibility to accommodate these increasingly complex rules.
- The re-design allows us to add new coverage plans and types of benefits more quickly and easily.
- The National Enrollment Database allows for centralization of portability; however, the current policy will require modification.
- Utilization of commercial std. Interfaces HL7 and X12 should decrease costs of managing/maintaining interfaces.
- HIPAA (1996) mandates that we standardize both identifiers and our electronic data interchange standards

B. Most important pieces of the redesign effort are the interfaces with the many, many groups within DEERS' medical scope – contractors, government agencies, etc.
C. A Web site has been developed within DEERS, to which people will have the ability to post questions; a calendar of activities will likely be included. Various DEERS/Medical documentation will be accessible online. Currently, the IOD and Business Rules may be accessed online. Implementation of this web application is ongoing.
D. Future Meetings: Janine Groth urged attendees to start thinking about who are the right people within represented organizations to attend conversion meetings, and to start identifying dependencies.

II. *DEERS 3 New Medical Document:* Presented by Larry Fobian
A. DEERS 3 Concepts: It reflects our attempt to integrate more with the commercial environment and includes the addition of a relational database. Currently, we are at DEERS 1.6; we are headed for DEERS 2 in April 1999. The biggest changes of DEERS 3, (the re-designed DEERS): the concept of "Health Care Coverage Plans" as opposed to

B. Assigned vs. Enrolled Health Care Coverage Plans: Those assigned by DEERS are based on derived entitlements, which determine what coverage plans one can enroll in. Enrolled plans are selected by the DoD members, based on their assigned coverage.
C. DEERS and Medicare: DEERS does not manage Medicare. DEERS can show/report Medicare entitlement when told of its existence for a beneficiary.
D. Subscriber vs. Insured: A subscriber is the person under the coverage is being provided. The insured receive coverage under the plan—e.g. family member and/or sponsor, depending on the coverage plan. In some cases, the subscriber may also be an insured (outlined in the document).
E. Eligibility for more than one DoD Health Care Coverage Plan: two cases:

- Multiple family memberships: example would be a husband and wife who were or currently are both in the military (Joint Service Marriage). This is currently poorly tracked in DEERS and is one reason for re-design.
- Multiple DoD memberships: someone is affiliated with more than one DoD organization. Example would be a retired military member on OCONUS assignment as DoD civil servant. This is currently not tracked at all by DEERS, but DEERS 3 will track by being person-based (one record).

F. System-Level Identifiers of DEERS 3:

- Family Identifier: uniquely identifies a family's information for storage and communication.
- Beneficiary Identifier: each family member is given this identifier within the family.

Together, the family identifier and the beneficiary identifier form the DEERS Identifier, which will enhance sharing and communication of info. about beneficiaries. These identifiers are used only for EDI and won't appear to the systems user or beneficiary.

III. *Current DEERS Medical Eligibility Matched Against New DEERS Health Care Delivery Program Options/IOD version 11/Business Scenarios 1 and 2/DEERS Medical Terms:* Presented by Kim Lynch
A. Reviewed definitions for basic DEERS terms, like "enrolling organizations" and "family members" (refer to the DEERS/Medical Terms sheet for complete list of definitions.).
B. Went through an Inquiry for Current Health Benefit Program Eligibility for Enrollment, found on page 38 of IOD version 11, followed by a run-through of Scenario 1 in the DEERS/Medical Business Scenario 1 document.
C. DEERS is excluded from identifying eligibility of abused persons that are eligible to DoD benefits. This is done through a secretarial designee and is managed by the different services.
D. How are same sex children from a multiple birth going to be distinguished in DEERS? Each person would have their own DEERS ID and Temporary Identification Number (TIN). Distinguishing what claim applies to which baby will be handled the same as it is today. There is no mechanism in DEERS which can help to eliminate this problem. DEERS should perform edits to ensure the beneficiary is enrolled in an eligible plan
E. Two issues raised by Kim:

- If you do an eligibility for enrollment for someone who was enrolled in Prime for six months, but who is currently in Standard, what DEERS will send back is the time

period he was in both (history segments). You'd get two eligibility programs back. This is discussed in the IOD, but we don't currently have a business scenario for it.

- If you did an eligibility for enrollment today, what is the time period it is good for? Five days in CHCS, but this isn't an issue for enrollment (although it is for other things). The group concluded that there is no specified time period, most eligibility for enrollment inquiries are done online in a real-time mode.

Action Items/Future Topics to be Addressed:

Web page address for DEERS: http://www.dmdc.osd.mil/deers/. Select DEERS documents to link to a listing of DEERS documents – including the IOD, Database Roles, and Business Rules as applicable to Medical.

Portability policy issues – review/action by TMA. How should 'Remote" Active Duty Sponsors be accommodated, i.e. a new coverage plan or an indication of benefit? Policy states a beneficiary can enroll wherever they want. EBC is done based on zip and so are contracts.

During OHI session:
Discuss incorporation of workman's compensation information.
Discuss incorporation of time/date stamp for the last update. The last update date for OHI would be helpful when OHI information is being returned in all inquiry responses. This identifies if the requestor has the most recent information about the OHI policy.

Occupational Health – applicable for patients, not DoD beneficiaries

Add a legend to the "New DEERS Health Care Delivery Program Options" document.

Add cat/cap totals to Eligibility response for enrollment of retirees and family members. Cat Cap and Deductible totals are needed when doing an Eligibility for Enrollment inquiry to assess if fees are applicable and what the fee amount should be. The totals are only needed when the applicable coverage plan for enrollment requires fees. Will this be accommodated by a single transaction or two separate transactions?

Question Kim Lynch asked everyone to consider during Person Updates discussion next week: "Who should DEERS accept address updates from in the medical community? Who should be excluded?" Mailing addresses are intended for mailing, not claims jurisdication.

Standard Insurance Table interface doesn't fit in the construct of X12. Need to discuss the EDI communication mechanism for SIT.

Demonstration projects – possible addition of coverage plans. Lt. Col. Larkin (TMA) will provide a listing of all demonstration projects.

DEERS needs to:

- have a mechanism to indicate waiver of fee payments.
- provide a list of hard/soft date conditions in regards to eligibility changes.

HCDP Copayment Factor Code and HCDP Special Entitlement Code are not needed for enrollment activities. The Pay Grade information provides the necessary information.

IOD Review Meeting Notes
12/3/98 (Day 2)

Referenced Documents:

Business Scenario 1 (enrollment scenarios)
DEERS/Medical Health Care Delivery Program

Discussion:

I. *Business Scenario 1 Document*: Presented by Kim Lynch
A. Three Systems used in DEERS notifications:
- Fee Management System: keeps anniversary date for re-enrollment and collect enrollment fee payments
- HCDP Enrollment Management System: CHCS, contractor—this is where we get enrollment information. Here is where DEERS IDs and policies are stored. These systems are responsible for maintaining and administering enrollments.
- PCM Enrolling Division System: tells contractor "these are your people."

B. Health Care Plans: see worksheet "DEERS Medical Health Care Delivery Program." Later, we will need everyone's help to validate this list.
C. Requirements for Enrollment: Page 53 of IOD version 11 lists the plans that require enrollment.
D. Coverage Plans Requiring Fees: see page 54 of IOD version 11. No enrollment fees required of Transitional Assistance Plan. No enrollment fees required for persons disabled under age 65 who are Medicare eligible and enrolled in Part B.
E. Lockouts: HPAA doesn't allow sending a reason for disenrollment to support lockout. Currently, DEERS does not have a field to support lockout. Timeline: next HIPPA meeting in Feb 99 – may decide then what to do with lockouts. In any event, DEERS does not plan to enforce enrollment lockouts.
F. Required Information for Enrollment:
- subscriber
- who is being insured
- plan the person is to be enrolled in
- enrollment effective dates
- optional information includes PCM information, OHI information, and person updates
- Currently enrollment end dates are not sent with an enrollment. Re-designed DEERS requires the end date for an enrollment and it cannot exceed 12 months or the end of eligibility, whichever is less.

- Enrollment in TRICARE Senior Prime cannot be done until the person actually turns 65.
- There is a requirement to indicate a fee payment is being waived. This would differentiate it from a fee payment that wasn't made at all.

G. What Happens When a Beneficiary Turns 65? DEERS sends a disenrollment notification by mail to each beneficiary, but the MCSC must actually process a disenrollment transaction.

H. DEERS doesn't track civilian providers, but is required to track PCM information for Direct Care/USFHP providers.

I. Changing Someone's Enrollment Date:

- To change end date: do an update
- To change begin date: must do disenrollment and a new enrollment
- DEERS does not enforce the payment of enrollment fees for coverage plans requiring them. DEERS will not perform triggers for payment of enrollment fees. These activities are the responsibility of the contractor.
- There was discussion around the re-competing and transition of enrollments between contractors and their systems. Disenrollment notifications are not contractor specific, but specific to the system managing the enrollment. The systems represent the trading partner and the computer system. The PCM enrolling division represents the organization responsible for delivering the care. DEERS will maintain who needs notification when there are enrollment transitions between contracts.

J. There was discussion regarding the National Payer ID (NPI), if it will represent a practice or just individual doctors. It appears from the discussion that the intent of the NPI is for individual doctors only, but this could change because the legislation is not finalized. DEERS should review how the NPI will be integrated with the PCM ID.

II. *Push Requirements*: Presented by Larry Fobian

DEERS pushes information when DEERS receives information that changes their assigned coverage, such as active-duty separation and retirement, but NOT when they turn 65. Being Medicare eligible at 65 and not being Medicare eligible below 65 are standard rules. DEERS doesn't push standard rules because DEERS has already told MCSCs during inquiry for enrollment. If beneficiary loses eligibility under age 65 because of Medicare, DEERS would push the information--in most cases beneficiary doesn't lose it, so DEERS doesn't push information.

<u>Action Items/Future Topics to be Discussed:</u>

Re-evaluate need for individual vs. family designation on coverage plans (HMHS will obtain). DEERS will not check to ensure family designation includes more than one person with that policy.

The portability scenarios discussed in Phoenix should be discussed at one of our meetings (Linda Donovan).

Does a fee collection policy defining single vs. multiple sources need to exist? (Sharon M./Kathy Larkin)

The prospect of tying individuals/families to fee payments rather than to their coverage, which is what is currently done—Janine suggested waiting until Brian is here on Monday to discuss.

Address updates represent jurisdictional issues for MCSCs – from whom shall DEERS accept address updates?

DEERS will need the capability to store multiple Enrollment Fee Management Systems for a policy. This situation occurs when there are split enrollments and fee payments are being made in two separate regions.

A new requirement for reporting individual fee payment detail was identified.

The idea of having several instances for a system id was discussed. The instance id would support the merging of regions and would allow multiple dis-enrollments to be sent by DEERS. There is a need to incorporate the sub-contractors into the system/instance id schema.

There was a discussion that suggested all initial enrollments (into coverage plans requiring them) should require a fee payment at that time. This suggestion would require a change to the current policy for CHCS because CHCS does no enrollment fee collection.

DEERS need to incorporate the PCM ID Type Code to indicate if the type of PCM ID is an SSN or a Tax ID.

DEERS needs to add a new business event to change the enrollment end date.

IOD Review Meeting Notes
12/4/98 (Day 3)

Referenced Documents:

Business Scenario 1 (enrollment scenarios)
DEERS/Medical Health Care Delivery Program

Discussion:

I. Newborn Enrollment Steps:
1. Inquire for eligibility
2. Send transaction to add a newborn person

3. DEERS adds newborn as person and assigns them their TRICARE Standard coverage for 120 days and gives them a DEERS ID, Temporary ID, and a Patient ID. DEERS cannot assign them to PRIME individual plan, this must be done through an enrollment transaction—policy states they are covered as PRIME for first 120 days, but PRIME ends after that unless they are enrolled.
4. MTF/Contractor sends conditional enrollment
5. If family isn't in PRIME, send end date for 120 days or sponsor's end eligibility date if less. If family already in Prime, they are enrolled within that policy for 120 days.
6. Newborn conditional enrollment
7. Verifying official contacts DEERS
8. DEERS notification time period change (not enrollment)
9. Newborn enrollment can be extended to the 12-month term or the end date of the family's enrollment If no verification is received, the enrollment expires after 120 days and the child is only eligible for Standard benefits.

II. Disenrollments
A. Disenrollments are required for each person in a policy.
B. Reciprocal disenrollments: By virtue of enrolling in one area, they are disenrolled from another. This occurs during a transfer of enrollment. Under current business practices, MCSCs should not be disenrolling people who are not enrolled in their region. Reciprocal disenrollments are only done by CHCS.
C. Split enrollment scenario: sponsor and children 3 & 4 live in Region 3, while his other two children 1 & 2 live in Region 5. All are covered by Policy 1. If the sponsor fails to pay the fees, region 3 (where the sponsor and children 3 & 4 reside) cannot disenroll children 1 and 2 in Region 5. Instead, Region 3 disenrolls children 3 & 4, DEERS would disenroll children 1 & 2 and then send notification to Region 5. In effect, DEERS would disenroll all in the policy. (Region 5 can request fee payment for children 1&2 and upon fee payment can re-instate enrollment with original enrollment effective dates).

<u>Action Items/Future Topics to be Discussed:</u>

If a child is attached to the wrong sponsor and claims accumulate, can we transfer their cat cap and deductible information to the proper person? (The contractor has the capability to adjust the cat cap and deductible information to back out the initial accumulation and send updates for the correct person using the Cat Cap and Deductible update transactions).

Contractors wanted to know how they could differentiate between multiple birth babies on DEERS.

Do we want to continue to add newborns conditionally? An alternative would be to require services to add them within 30-60 days.

Should a newborn be enrolled in his or her own plan? This revolves around the Individual vs. Family Coverage plans. If the newborn enrollment begins a family enrollment, how are all family members enrollment dates synced up, is it a new policy, hence a new enrollment?

What region and PCM should be assigned to newborns? If the mother is enrolled in Prime, the PCM can be the same as hers; Otherwise, should DEERS have a dummy PCM for newborns?

How are newly adopted baby enrollments handled? Are they handled like other newborns? No. There are papers associated with wards and adoptions. These papers must be presented to a VO for these individuals to receive DoD benefits.

If newborns are to be enrolled for only a 120 period, ADP manuals need to reflect the change from the current enrollment period of 365 days.

Split family disenrollments: Can the region that holds the sponsor disenroll ALL on the policy/possible with portability?

IOD Review Meeting Notes
12/7/98 (Day 4)

Referenced Documents:

Interface Operation Description version 11
Business Scenarios document (scenarios 1h and 1i)

Discussion:

I. Re-enrollment (refer to p. 58 IOD):
A. Required on all coverage plans that require fees; provided by enrolling organizations to DEERS.
B. DEERS performs re-enrollments for those plans not requiring a fee (these people are continuously enrolled, from a database perspective).
C. Required information for re-enrollment found on IOD p. 59.
D. Re-enrollment on a split enrollment: we stated previously that when you disenroll a policy, you disenroll only those individuals in your region. Contractors can re-enroll their participants only.
E. The idea about a designated payer for split family enrollments was discussed. TMA Issue: The contractors would like TMA to consider establishing a designated payer.
F. There is a 10-day grace period for re-enrollments. This grace period considers the beneficiary eligible for Prime coverage. This is particularly important during pharmacy claims. The pharmacy needs to know if the person is eligible for the prescription and how much to charge. Is it possible for DEERS to derive an intermediate “grace” period for Prime eligibility upon inquiry?
G. Auto renewal for policies will only be done by DEERS for Active Duty Sponsors. Re-enrollments for TRICARE Senior Prime are not applicable because the enrollment is for a

defined period of time. Re-enrollment transactions need to be performed for all coverage plans requiring an enrollment by enrolling organizations.

II. Fee Payments:
A. Enrolling organization responsibilities: Per page 64 in IOD version 11, DEERS doesn't store individual payment amounts/doesn't prorate fees; DEERS doesn't determine the amount of next enrollment fee payment; DEERS doesn't determine the date of the next enrollment fee payment.
B. Fee payments are associated with the subscriber of the plan – not with each individual person in the policy.
C. If there are multiple regions collecting fee payments, and an overpayment occurs, who should the refund go to? DEERS only reports total fee payments collected. An inquiry to DEERS will return the total fee payment received thus far for a policy. There was a new requirement to give a ledger of fee payments received for a policy. If this is approved, it could help facilitate the refund. However, DEERS is not responsible for refunding enrollment fees or determining the amount of a refund. These activities are the responsibility of the fee management and enrollment management systems.
D. Once a payment plan type has been selected, it cannot be changed during the enrollment year.
E. If there is a split enrollment, and DEERS receives a re-enrollment transaction from one region, DEERS will re-enroll all beneficiaries covered under that policy and send a re-enrollment notification to the other region so they can perform the re-enrollment on their system.
F. Under the individual and family coverage plans, how are enrollment fees applied from the individual policy toward the family policy? There is a disenrollment from the individual policy and the negative and positive fee payments are used to transfer the funds to the family policy. It is suggested that whoever initiates the change in the policy determines length of new enrollment. Additional people added to the policy will assume the end date of the current policy.

III. CAT Cap and Deductibles:
A. Based on either fiscal year or enrollment year anniversary, depending on plan:
1. Tricare Std. cat cap & deductible based on fiscal year.
2. Tricare Primary cat cap & deductible based on enrollment year anniversary.

IV. Claims:
A. The goal of the information DEERS provides is to give what is needed to process a claim. We reviewed scenarios 1h and 1i.
B. Elements for coverage inquiry:
1. Person identification
2. Delivery program (pharmacy, health, dental)
3. Begin and end date for claim period (can be a date range or a single day)
B. Response elements:
1. Person ID
2. HCDP type

4. Coverage segments for the request period
5. OHI, NAS, OGP (OGP is where you'll see Medicare info., part A and B will be separate segments) information
6. Contractors emphasized their need to get information as of the date-of-care.
Decided that several fields could be removed from the current sponsor information section of the response. Please refer to the table below.

Delete:	**Keep:**
person death code	person death date
service code	UIC history (The contractors would like UIC history. DEERS does not carry UIC history).
pay plan code	
pay grade	
pay grade date	
rank code	
work location country code	
work location zip code	
person association begin date	
person association end date	
person association reason code	

7. Contractors keep the inquiry/response associated with a particular claim. The claim number needs to be incorporated into the message and this could be done by adding it to the trace number in the X12 message header.
C. OHI Information for claims:
1. Have: OHI Carrier, OHI policy
2. Need:

- OHI type (PPO, HMO)
- OHI effective date
- OHI expiration date
- Pharmacy coverage flag

D. Example of "no coverage" business scenario: Refer to scenario 3/reservist on active duty.
E. The pay grade at the time of enrollment remains the same for the entire enrollment period. If the service member is promoted within the enrollment year, the co-payment factor would change at the time of re-enrollment if applicable. However, there will be a new Health Care Coverage segment which would have an End Reason Code of Pay Grade Change.

V. Enrollment of Newborns (please also refer to IOD Review Meeting Notes from Day 3 for more information):

- Whoever first sees a claim for newborn inquires DEERS for eligibility, send transaction to add newborn to DEERS.
- Contractor or MTF send conditional enrollment putting infant in PRIME for 120 days.
- Family goes to verifying official, who updates DEERS, and DEERS notifies contractor.
- Enrolling organization enrolls them in proper plan.
- Potential problem: If between the baby's birth and submission of claim, the family transfers enrollment (i.e. baby born in Virginia and then family moves to Texas). Between the date of birth and the date of transfer, there is a hole.

VI. Miscellaneous Discussion

- A PCM change between two regions is a transfer of enrollment, not a PCM change. PCM changes are only those done within the same region.
- DEERS will include coverage segments for the entire inquiry period. If the person was not entitled or eligible for DoD benefits, there will be a coverage segment indicating this condition.
- Mailing address are not kept historically in DEERS and cannot be used for claims jurisdiction. The Health Care Coverage segment information should be used for claims processing.
- DEERS should review why the PCM Selection End Reason Code is returned during the Eligibility for Enrollment Inquiry.
- The only address information that should be sent to DEERS when making person updates is the address information that is to be updated in DEERS.
- Enrollment fee payments will not automatically be applied to CC&D by DEERS because the cap may be met, locking and the implications of CC&D to totals. This function is a contractor responsibility.

<u>Action Items/Future Topics to be Discussed</u>:

Ten day grace period for eligibility for re-enrollment (pharmacy claims) What is the policy for the grace period for re-enrollments? DEERS is under the current assumption of 10 days? DEERS to evaluate the feasibility of determining a "grace" period of eligibility during the 10-day grace period for re-enrollment?

Sharon Morganthall is looking into the policy for re-enrollment. It has also been documented that the grace period is 21 days.

How to handle PCM changes during grace period or beyond end date; PCM changes would only be applicable after a re-enrollment transaction. It is a business practice if the change of PCM signifies a re-enrollment.

Disenrollment transaction for non re-enrollment from enrolling organizations; Should enrolling organizations send a disenrollment transaction to DEERS when they know there

will not be a re-enrollment for a policy? Yes, for policies that are set up for automatic re-enrollment.

GSU – PRIME REMOTE and REFERRED CARE

- requirement for UIC?
- Requirement for UIC history?
- Should there be a coverage plan for Remote? Alternatively, should there be network provider type code associated with Remote? Assumption – there is no access to an MTF and therefore there would be a Civilian PCM. Should the DMIS ID, 6902, for Civilian PCM for Remote be eliminated because there isn't an enrolled organization for providers in the Civilian network because DEERS is not required to track civilian providers?

Death: AD/RET (one year) How does coverage information show for the sponsor and family members; Is the sponsor still the subscriber?

EIS: Claims Inquiry: put claim # within message

TMA: Retrain providers to provide family member SSN on claim form in addition to sponsor SSN

Eligibility inquiry prior to DEERS eligibility.

How are re-enrollments handled for split enrollments? There can be multiple fee payers and who is responsible for paying the fees for the policy, which region is responsible for collecting the fees? Is it possible for the family to have a different policy for each region even though it is the same coverage plan?

Q: Jan. 1-Dec. 31 1998: no re-enrollment fee or information received by DEERS. What happens in Jan. 1999?
A: (Kim Lynch) There is a ten day grace period. If during the 10-day grace period they re-enrolled, backdate to the 1st of January. If during those 10 days we received a disenrollment, from that point forward they would be in Standard and they'd be disenrolled as of Jan. 1, 1999. If on the eleventh day we still haven't received a re-enrollment, they revert to Standard, backdated to Jan. 1, 1999.

Are cost shares affected when a pay grade changes in the middle of an enrollment year? What is the impact to persons with a disability?

DEERS should ensure there is a Health Care Coverage End Reason Code for Pay Grade Change when a new segment is created due to this event.

The business rules need to be updated to have name as optional, it is not required for the business event. However, the name is required by HIPAA in X12 and should appear on the transaction.

DEERS should create a matrix that illustrates when the Person information, DEERS ID and Patient ID are to be used in the different business events.

Contractors need to supply the explicit information for OHI needed for claims processing.

DEERS needs to create the list of events that would trigger a change in coverage.

DEERS needs to create business scenarios for NAS.

DEERS should add a type code to the CC&D dollar amount. The type of adjustment could be a fee payment, claim, or other. This would allow the tracking of adjustments being made to CC&D totals and how they were accumulated.

What is the impact of continuing change orders to the contractors and the work needed for redesigned DEERS?

IOD Review Meeting Notes
12/08/98 (Day 5)

Referenced Document:

Business Scenarios (claims portions)

Discussion:

I. 95 % of the interaction between DEERS and the contractor systems will be machine to machine. This is no human intervention except to handle exception conditions whose resolution can not be handled through system applied rules. The contractors cannot tolerate a process that introduces human intervention. They would not be able to meet their current processing volumes and cycle time.

II. Enrollment Year (EY) and Fiscal Year (FY) Catastrophic Cap and Deductible (CC&D) Accumulations and the Interaction with DEERS with Respect to Fees, OHI Amounts, and Waiver of fees: Presented by Marcia Renzullo/Larry Fobian
A. DEERS has 3 buckets
1. Tricare Standard
2. Tricare Prime
3. Point of Service

Note: Cost share means patient pays a percentage of the bill. Co-pay means the patient pays a flat rate for covered services.

Illustration:

FY (Standard)	EY (Prime)
1. FY Deductible	
1. FY CostShare	
2. Enrollment Fees	2. Enrollment Fees (non-active data)
2. Enrollment co-pay	2. Enrollment co-pay
2. Enrollment cost share	2. Enrollment cost share
3. POS deductible	
3. POS cost share	

B. If FY cap is met, this waives Tricare Prime enrollment fees, co-pays, and cost shares for the remainder of the fiscal year for the family. Is there then a need to pay EY prorated fee?
C. If EY cap is met, enrollment fees, co-pays, and cost shares waived for remainder of enrollment year.
D. What OHI amounts (enrollment fees, co-pays, etc) are applied to the FY and EY CC&D accumulations?
E. DEERS provides buckets (accumulation categories), stores data, and adds accumulating totals. Contractors provide data – DEERS acts as a passive repository. Transaction history is used by contractors to fix errors.

- Janine Groth: DEERS may be able to provide a transaction history for FY and EY as well as totals – dependent on a request. DEERS may need an FY/EY query. This may not be appropriate to provide via X12. DEERS will research the most appropriate method of implementation. Claim # and contractor can be stored by DEERS, possibly in the X12 message header.

F. Issues for TMA:

- No consistency among contractors for coordination of claims, enrollment year catastrophic cap and deductible processing.
- Which data fields to post for the Explanation of Benefits form (EOB) is unclear. Clarification needed by TMA for MCSCs on which figures to use from DEERS and which ones from their own systems – totals from either source may not be unsolicited.

G. Accumulations are done by family. Family means 2 or more persons and the policy has a single anniversary date. Individual means single person.
H. Currently, if two persons are enrolled in Prime and then another member is added, the new member's end enrollment date is the same as the family's end enrollment date.
I. The contractors agreed that the policy should state that if there is more than one person in Prime, then the grouping should be treated as a family. Currently, if <u>one</u> person is enrolled in Prime and another member is added, the policy is now changing from Individual to Family.

- New family policy requires a new begin enrollment date and end enrollment date.
- Prorate fees from individual to family

- New anniversary date established
- Currently, they would lose any amounts accumulated against the cat cap and deductible. Issue: TMA needs to decide if this is correct.
- Issue: If in the future the start date changes for the "new" family policy and the individual end date is kept, are fees prorated for addition of a member?

J. Business Practice Issue: Who is the fee payer if there is a family policy in existence in 2 different regions?

Example: Person has individual policy and is fee payer with enrollment year from Jan 1 – Dec 31 (Individual policy). New member is added March 1 in a different region. What happens in terms of fees and coverages?

- Jan 1 – Feb 28 (Indiv Policy)
- Mar 1 – Feb 28 of next year (Family Policy)

OR

- Jan – Dec (Family Policy)
- Region doing individual to family policy adjusts fees with new enrollment.
- DEERS does disenrollment and sends a disenrollment notification to losing organization, gaining organization does re-enrollment.

K. Issue for TMA: Need policy for designated payer, MCSC responsibility, and definition of individual and family. The contractors want a hierarchy for determining the designated payer. If current policy stays, then this is a coverage issue and DEERS needs to maintain Individual and Family Plans.

- Can 2 family members each have an individual policy (separate enrollment years) in 2 regions existing concurrently?
- Fees cannot be sent unsolicited if multiple points of payment – dependent on a single payer decision.
- If there is a change of individual to family across regions, DEERS must send a notification to the organization that enrolled the individuals and the fee system.

L. Claim number isn't unique, but DEERS also needs to include claim organization source code to associate with the claim number. Suggest that the claim org source code be done by region, not contract because of merging of contracts.

M. DEERS applies individual amounts to Standard, Prime, and POS buckets, detail lines. MCSCs also apply fees, adjustments to claim number or fees. What identifies an individual posting?

N. Issue: In split claims for both FY and EY, what happens to HCSR? Does DEERS need to accept a cat cap and deductible type of adjustment code? Yes, get from ADP Manual, Chapter 11.

O. Cat cap and deductible are done by DEERS ID.

P. Portability Issue: USFHP only does enrollment year cap. Upon transfer from USFHP to Prime, USFHP fees may need to apply to CC&D totals.

- TMA: How does this impact the MCSC keeping track of CC& D when transferring into Prime?
- USFHP has no intention of posting CC&D to DEERS – currently there is a manual process in place. Form indicating what applies to MCSC CC&D comes with the beneficiary when the transfer occurs. The MCSC can send a CC&D update to apply these amounts.

Q. FY totals – Standard by Family ID and Beneficiary ID (Individual)
R. EY totals – Anniversary date for family, add Prime
S. CC&D kept on DEERS within 3 years past loss of eligibility in effect.
T. Issue: How far back in records to go for Conversion?
U. DEERS may want to consider receiving a date range for claim update – begin date and end date associated with a claim record. But this won't work because the responsibility for determining the amount to apply to each FY and EY resides with the MCSC.
V. Issue: Individual vs. Family Policy. Areas of impact:

- Remote
- CC&D
- New enrollment periods
- Split enrollments (separate regions)

III. Claims Inquiry for Processing: Presented by Marcia Renzullo
A. Inquire for coverage eligibility, then adjudicate the claim.
B. Need FY and EY dates for inquiry. DEERS may want to include a date range
C. DEERS needs to look at keeping EY and FY totals. MCSCs send EY and FY for CC&D amounts. Process date determines when beneficiary meets the cap.
D. Locks for Claims

- Matrix from Sharon Morganthall
- One claims processor processes in batch, 1 in online.
- DEERS needs the claim by claim look option.
- DEERS needs to add claim number to lock. Only unlock when that claim number is sent with unlock from MCSCs' systems.

E. POS has CC&D processing by FY, not EY. POS has no catastrophic cap.
F. MCSCs need to know that the update for claim 1 applied before inquiry for claim 2 within the same organization.
G. Fiscal year CC&D is for the second half of the enrollment year.
H. No Prime deductible (no such thing) for CC&D totals
I. Locking claims totals: If the MCSC intends to update catastrophic cap and deductible balances, they must lock the totals and indicate what type of update is being made (claim number, enrollment fee, or adjustment (non-claim)).
J. Upon a claims inquiry, if an MCSC sees a lock placed by another organization, the MCSCS want DEERS to send an acknowledgement saying the MCSC did not get the lock. DEERS does not need to return additional information, such as totals, etc.
K. DEERS keeps a 48 hour lock.
L. DEERS will keep the update with the continue lock option.
M. If a lock exists, MCSCs only send a lock indicator if intent is to lock.
N. Concern of claims lock associated with enrollment fee application if just an inquiry for totals return information.
O. TMA Policy: Should a lock be required for applying fee payment.
P. DEERS needs to store update # -- ie. Claim #, fee #.
Q. MCSCs can lock only at claim #. MCSCs can update CC&D for same claim number without suffix. DEERS stores claim # with suffix at update level for history.
R. MCSC send EY and FY date in MM/DD/YYYY format.

S. If enrollment date begin date changes, (net disenrollment/enrollment) DEERS needs to send notifications to MCSCs for claims service dates under review.

IOD Review Meeting Notes
12/09/98 (Day 6)

Referenced Documents:

Standard Insurance Table/Other Health Insurance (SIT/OHI)
Business Scenarios (OHI portions)
Interface Operation Description version 11 (OHI, pharmacy inquiries)

Discussion:

I. Military Treatment Facility (MTF) – CHCS Current Process: Presented by Rose Layman/Brian Kitzmiller
A. CHCS uses query for MTF's Standard Insurance Table for OHI information. SIT contains OHI information needed for 3rd party collection transactions. Also used anytime a beneficiary has an encounter with an MTF/CHCS site.
B. SIT assigns a Standard ID for every insurance company on the table and returns that value in queries. In the future, HIPAA will require using the Payer ID as the SIT ID.
C. If Insurance company is not on MTF's table, a CHCS site may send an update. The MTF assigns a Temporary ID, until all information has been verified.
D. At MTF/CHCS site, beneficiary signs statement stating that OHI information is correct. OHI verified by copy of OHI policy being physically attached to a patient's medical record.

II. Redesigned DEERS Process:
A. DEERS will maintain a Standard Insurance Table and an Other Health Insurance table.
B. Standardization procedures will be in place to keep SIT/OHI in sync.
C. SIT table will be accessible from DEERS to MTFs and MCSCs – able to download onto local systems.
D. DEERS sends SIT update transaction, but inquiries required for an individual claim or policy.
E. Issue: MCSCs don't want to have beneficiary records modified in CHCS and then be out of sync with DEERS.
F. Temporary Insurance Company record exists with temporary ID until verified by DEERS. DEERS will link the temporary ID with the SIT ID so either ID is acceptable for inquiry or processing.
- DEERS sends temp ID and verified SIT # for reconciliation that can be done locally.

G. Number of SIT entries – 5000 in 1996

H. New table for SIT in spring 1999, another 2500 entries.
I. Post SIT in DEERS before storing data locally
J. Frequency of SIT verification or updates by DEERS is currently unknown.

III. OHI Information: Presented by Steve Dellaporta
A. OHI policy:

- Links to Sit -- OHI Carrier ID is the SIT ID
- Exists at individual person level
- DEERS does not push OHI updates
- DEERS may need to store history for OHI – Update date and OHI Update Organization
- OHI information returned by DEERS on inquiry is for only OHI Active calendar dates.
- Dual-Eligible Medicare Supplement equals OHI, else Tricare supplements pay last.
- Number of OHI policies returned (segments) – 3 to 10?
- DEERS needs business rules for OHI – Steve Dellaporta.

B. Business practice issue: Process for people to inform/sign/document persons not covered under an OHI policy of another family member.
C. In the future, MCSCs role with SIT/OHI:

- Should provide OHI information
- Must react to OHI if DEERS indicates OHI exists
- Must resolve OHI
- Require current documentation to support OHI
- Update policy and contracts to ensure commonality

D. Issue: Can claim be processed while SIT verification being performed? Answer: OHI policy not being standardized and SIT verification should not affect OHI claim processing.
E. Issue: What is process to inquire SIT and update SIT?

- X12 doesn't support adding SIT entry with OHI update

F. CHCS carries priority code and can vary based on type of claim. Example: Health vs. Pharmacy, this priority is determined at claims processing.
G. Type of OHI coverage and review indicators from WPS/PGBA met priority
H. DEERS needs a way to indicate HMO, PPO
I. What is the frequency of OHI data change?
J. MCSCs want all OHI and NAS for claims only, not enrollment.
K. Issue: OHI policy and a unique ID are necessary – perhaps the effective date would not be changeable.
L. Issue: What is the definition of an OHI change versus an OHI correction?

IV. OHI Information for Claims: Presented by Marcia Renzullo
A. OHI Inquiry fields required for claims processing:

- OHI Carrier
- OHI Policy
- OHI Type (HMO, PPO)
- OHI Effective Date (Begin Date)
- OHI Expiration Date

- OHI Carrier Coverage Type – Insurance lines of business
- OHI Update date
- OHI Update Source code

B. MCSCs want to have OHI inquiry as part of Claims response. Is this possible?

V. Pharmacy: Presented by Brian Kitzmiller/Steve Dellaporta/Larry Fobian

A. Includes National Mail Order / BRAC Pharmacy as well as usual pharmacy benefit available to beneficiary

B. Pharmacy benefit is based on eligibility. Beneficiary able to use BRAC and regular pharmacy benefit concurrently.

C. No cat cap on BRAC Pharmacy.

D. Contractor determines pharmacy cost share – DEERS does not.

E. DEERS response time is 2 seconds from the time it receives a request until the time it leaves the system. Comm time (IDSN etc.) is not included in this estimate.

F. MCSCs total event time for MCSC system and pharmacist interaction is 15 seconds.

G. Currently, attempting to get a prescription filled out of the region is rejected.

H. Pharmacy inquiry fields:

- Patient demographics
- HCC
- OHI
- No PCM/PCM Network Provider Type Code
- No OGP
- No Worker's compensation
- No NAS
- Possibly have pharmacy use Person ID, SSN/TIN, or ID card. Send sponsor and family member SSN for match on DEERS.

I. Pharmacy inquiry on a newborn – override because baby doesn't exist on DEERS. Claim is the triggering event to conditionally enroll the newborn. If baby is on DEERS and no enrollment yet for Prime, DEERS eligibility returns Tricare Standard HCDP. Claims procedure determines Prime coverage and can cause pharmacy to charge Prime cost share.

J. Illegitimate babies are not put on DEERS database until paternity is established – same for today's world and tomorrow's world.

VI. X12 Information and Conference Discussion: Presented by Gary Yager/Janine Groth

A. Websites: www.disa.org (X12). www.wpc-edi.com (Washington, publishing). These links are not education/tutor based for HIPAA or X12.

B. EIS next version due on Jan. 4th. Will be focus for upcoming EIS Review Conference.

C. Upcoming conference information:

- EIS Session 1. Jan 10 – 15, 1999. Alexandria, VA. The 10th and 15th are travel days. Plan on the 11th – 14th to be full day sessions. Focus is 270/271 messages – Eligibility for enrollment, OHI, Coverage, Claims, MTF. Review X12 transactions for Cat cap and deductible totals and updates. Attendees should include TMA, MCSCs and their Subs, CHCS, and DEERS. Please bring one individual who attended the IOD sessions and an individual(s) knowledgeable about X12.

- X12/HIPAA Conference – Feb. 7-12. DEERS and TMA representatives will attend.
- Feb 7 – 12, 1999. Denver, CO. Travel day on the 7th. Focus on conversion, Database synchronization, enrollment end date, cat cap and deductible, Person ID, and OHI. Attendees include TMA, WPS, PGBA, and DEERS.
- EIS Session 2: Feb 22 – 26, 1999. Alexandria, VA. Travel day on the 22nd. Focus on 834 message – Enrollment/disenrollment, OHI, Person Updates. Attendees should include TMA, MCSCs and their Subs, CHCS, and DEERS. Please bring one individual who attended the IOD session and an individual(s) knowledgeable about X12.
- EIS Session 3: Mar 8 – 12, 1999. Travel day on the 8th. Alexandria, VA. Focus on 278 message – Claims, SIT, NAS. Attendees should include TMA, MCSCs and their Subs, CHCS, and DEERS. Please bring one individual who attended the IOD session and an individual(s) knowledgeable about X12.

D. Filter answers as DEERS gets them. Change order packages may be sent after EIS sessions.

E. Project scheduling issues: Need overall realistic development and implementation schedules for each organization. From these schedules, we will work together to develop a global schedule. This global schedule will drive the dates. In addition, TMA needs rough order of magnitude estimates necessary for project budgeting.

F. Current TMA/Contractor process: All manual instructions, ADP changes go out. Contractors have 30 days to respond with comments (no costing yet). Contractor comments are coordinated into final package. This goes out for implementation with respect to testing timeframe, file turnover, final implementation date. Contractor funded when the first change is issued – independent cost estimates as well as ongoing maintenance costs are documented as well.

- Charging entire cost of implementing HIPPA is a separate line of business. DEERS would be involved in preparation of any final packages sent by TMA to the contractors.

<u>Action Items/Future Topics to be Discussed:</u>

Ensure all contractors receive answers to questions/issues documented.

Decisions stay as communicated – conference call in January with core group of individuals will help facilitate that.

Executive Steering Committee – Need support of this idea. Former answers have been NO. Project needs to clearly identify questions to TMA, format them, ask, and format response for distribution to all entities involved. Answers will be posted to the DEERS Web site.

All involved entities must make sure the Points of Contact (POC) demographic information are current and accurate – email, phone number. POC's role is to distribute information, gather comments, incorporate comments in project information, redistribute, etc.

Project needs to identify DEERS reporting requirements – extracts, CEIS as well as document DEERS push requirements and activities.

IOD Review Meeting Notes
12/10/98 (Day 7)

Referenced Documents:

Interface Operation Description version 11(General Updates)
Interface Operation Description version 11 (OHI, Pharmacy inquiries)
Business Scenarios (NAS portions)
Business Scenarios (MTF Coverage)

Discussion:

I. Person Updates: Presented by Marcia Renzullo
A. DEERS needs a list from TMA of who is allowed to send address updates.
B. Can this transaction be used to add a newborn person? See IOD Versions 12 for how to add a newborn.
C. MCSCs should store SSNs when they are sent by DEERS.
D. DEERS does not store historical address.
E. Issue: Can Claims, Pharmacy processors change addresses?
F. Issue: TMA (Linda Miller) – Policy for storing historical addresses. Is this a new requirement for DEERS or should the MCSCx store addresses historically tied to claims. The contractors need the current address for billing and EOBs. For claims, the contractor wants the address at the Date of Service of the claim.
G. DEERS should check effective date of address update to prevent overrides. Example: If personnel centers send address updates with the date and MCSCs also sends effective date – a period of flux is possible.
H. OPM cannot accept P.O. Box, DoD cannot legally dictate that people supply a physical address.
I. Change in Mailing Address Date is the same as Mailing Address Effective Date.
J. Address is important for EBC for Standard beneficiaries. EBC for Prime is done on where an individual is enrolled. This also impacts Bid Price Adjustment.
K. Suggestion: DEERS change Mailing address to Residence address and have new requirement to track Mailing address. Dead Beat Dad act requires sponsor to change address within 30 days of a move. MCSCs don't want a legal residence if they will have to track residence address.
L. DEERS re-examine need for residence vs. mailing address. TMA cannot enforce it unless it is made a DoD policy. Contractors update addresses bases on enrollment application address.
M. Extracts – CEIS, EBC. Enrollment data, NAS. Who is contact for communicating with DMDC?

II. NAS/Newborns: Presented by Kim Lynch/Brian Kitzmiller

A. Newborns – if baby is Prime, no NAS required.

- All Active Duty babies are Prime automatically for 120 days.
- In a retired family, if one member is Prime, then baby automatically Prime for 120 days. If no Prime, then baby is eligible for Tricare Standard.

B. NAS Inquiry

- Machine to machine query – no human response required.
- Process flow: Contractor inquiry→ DEERS response→Tracer # → has to be attached to claim. DEERS needs to track Control # and Transmission # for NAS – always part of transaction.
    - NAS ID – Generated by DEERS – will contain DMIS ID (from MTF) for Inpatient care.
    - NAS Calendar Issue Date – Good for 30 days.
    - NAS Admitting Facility – Used for OHI name.
    - NAS ID – Generated by specific facility for Chronic care
    - MCSCs indicate that 75% of NAS are issued retroactive – how is this handled by DEERS?

C. If OHI exists, no NAS required. It is the responsibility of the contractor to determine if the OHI covers the NAS. DEERS will not edit this.

D. No conditional NASs exist.

E. Issue: How does DEERS identify outpatient facility – needs to be flexible to allow change based on BRAC.

F. STF – Specialized Treatment Facility (Heart transplant, etc.). DEERS does not have requirement to track care related to STFs.

III. Push Data: Presented by Larry Fobian

A. DEERS data pushes involving unsolicited conditions. Frequency: At best hourly, at worst it's once every 24 hours.

B. 3 databases exist: DEERS, MCSC, CHCS (MTF). Different databases have authority as database of record on different things.

C. Health Affairs mandates that DEERS is database of record for eligibility. DEERS is a repository for enrollment.

D. DEERS acknowledges that it does not provide connection 7 x 24. DEERS is not available during standard maintenance time periods (approximately 30 minutes per night and 4-6 hours each weekend).

E. Issue: If separate systems for enrollment and fees, are they reported as Prime? Answer: DEERS accepts them as Prime, Rx claims aren't paid until fees paid. DEERS notifies pending states of fee payments

F. If CHCS does enrollment and MCSC does fees: DEERS won't know to send information to MCSC because DEERS doesn't know about the MCSC until the fee payment is received.

G. Health Affairs and TMA mandate that no person may be enrolled past his/her end of eligibility.

H. DEERS will add push/no push information and hard dates into the IOD.

- TAMPS – DEERS pushes data at time of change, no information sent at initial eligibility.
- Split enrollment – DEERS sends notifications to multiple parties
- DEERS will not send disenrollments for non-payment of fees. That is the MCSC responsibility to send the transaction to DEERS.
- DEERS will push data on events created by MCSCs and CHCS.
- DEERS does not push external IDs except through responses to inquiry events.
- DEERS IDs per beneficiary: can still use TIN when SSN is added.
- DEERS IDs/Patient IDs is link to other systems. MCSCs can apply this locally.

I. TMA Issue: 10 day (x days) grace period for re-enrollment. How will this be handled with DEERS and MCSCs?

IV. EIS Conference logistics: Presented by Janine Groth
A. EIS next version – Jan 4, 1999.
B. MCSC concern for getting people up to speed on X12 for sessions.
C. What are the official channels of communication for information to go from IOD Issues to Primes and Subs?
D. MCSCs want in IOD version x to be in sync with EIS version x. IOD changes with revision borders on the side. Changes need to be reflected in EIS, IOD, business events
E. After final rule, two years to comply with HIPAA legislation for large companies, 36 months for small companies. Final rule could be here in 3 – 4 months.
F. Differences between 4010 and 4030?
G. Need to publish indications of changes to the HIPAA implementation guide in the EIS.
H. Project scheduling

- When willtesting take place? Not a point of discussion due to changes occurring.
- Possibility of phasing in terms of eligibility, enrollment, claims, etc.
- DEERS needs transaction volume estimates from MCSCs.
- Discrepancy and return codes lists – when will these be available? We will discuss general error handling at the EIS sessions.
- At what point in design will documentation requirements be discussed to include creation, distribution and maintenance?
- Which transaction sets will be used?
- Research ADP manual, Chapter 9 for reference.

V. NAS: Presented by Kim Lynch
A. If Patient IDs by HIPAA passes legislation, DEERS Patient IDs would be replaced by it.
B. MCSCs want V.O. to pick sponsor so child is only under one sponsor – is this feasible?
C. DEERS needs to send Sponsor/subscriber for NAS Issuance
D. Issue: How are 2 DEERS IDs handled? Example: A child may have 2 DEERS IDs based on parents' situations – one in Prime, one in Standard. DEERS needs to perform edit to make sure "person" does not have 2 Prime enrollments. Can check Person ID, but SSN is only true identifier of a single person.
E. DEERS will edit that the DMIS issuing facility is an inpatient facility.
F. DEERS will not allow issuance of NAS for a Prime enrollee.

G. For OHI, DEERS needs to look at when Admitting Facility Date is populated.
H. TMA Issue: Does Admitting Facility need to match claim facility for retroactive NAS?
I. NAS Issuance: Issuing facility has "medically inappropriate" code.
J. MCSCs indicate that for claims processing, if NAS not on DEERS, then procedure is to look for NAS paper
K. DEERS will put reasons for NAS Issue into the IOD.
L. Issue: Remove OHI from NAS form
M. Issue: MCSCs would like DEERS to push NAS Cancel.

VI. Patient Updates:
A. Name Changes
B. Death Code
C. Text about Blood Type verification DBSS.

VII. Other Contractor Issues:
A. TMA: Should DEERS store the civilian PCMs? This is currently not a requirement. The contractors feel that they cannot rely on DEERS as the NEDB without this information stored centrally.
B. B. TMA: Is the beneficiary actually enrolled in Prime if DEERS has not received the fee or should DEERS pend the enrollment?
C. TMA: TAMP goes away 9/30/99. Should DEERS still implement requirements for TAMP?

VIII. MTF Coverage Inquiry: Presented by Steve Dellaporta
A. Leave Person Association in MTF inquiry even though removed from claims
B. Add segments "Prior to eligibility" for all scenarios.
C. Issue: Can DEERS have 2 addresses for same person – i.e., retired and civil servant?
Answer: Currently, DEERS has no requirement to track 2 addresses.
D. Current HCDP Policy: Beneficiary can be enrolled in only a single plan at any one given time. Note that enrollment is based on assigned coverage.
E. Issue: No MTF PCM Update exists. Should this be a new requirement?